Your Guide to the Outpatient Prospective Payment System

A New Way that Medicare Pays for Outpatient Services

Learn about:

- **Payment for most outpatient services you get in a hospital or community mental health center in the Original Medicare Plan**
- **Your rights and protections**
- **Where you can get help with your questions**

HEALTH CARE FINANCING ADMINISTRATION
The Federal Medicare Agency

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Your Guide to the Outpatient Prospective Payment System explains the new way that Medicare will pay for most outpatient services. It is not a legal document. The official Medicare provisions are contained in relevant laws, regulations, and rulings.

Who Should Read This Booklet

If you have or a family member has the **Original Medicare Plan** (also known as fee-for-service), you should read this booklet.

This booklet explains changes in what you will **pay** for most Part B **outpatient services** you get that are covered under the Original Medicare Plan. These changes only affect the **payment** for most outpatient services you get at a hospital or **community mental health center**.

If you are in a **Medicare managed care plan** (like an HMO) or **Private Fee-for-Service plan**, the outpatient prospective payment system does not apply to you.

For more information on Medicare managed care plans or Private Fee-for-Service plans, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of *Medicare & You* or *Your Guide to Private Fee-for-Service plans*.

If you are not sure if the outpatient prospective payment system applies to you, call 1-800-MEDICARE (1-800-633-4227).

Terms in **red** are defined in Section 5 on pages 23-25.

A Quick Look At The Outpatient Prospective Payment System

What basic things do I need to know about the outpatient prospective payment system?

The basic things you need to know about the outpatient prospective payment system are:

- It is a new way that Medicare will **pay** for outpatient hospital or community mental health center services.
- It changes how much you pay and Medicare pays for outpatient services.
- Depending on which services you get and the hospital where you get these services, your out-of-pocket costs may be higher or lower than they were before for the same service.
- It will lower your out-of-pocket costs over time.

A Quick Look At The Outpatient Prospective Payment System (continued)

What services are paid for under the outpatient prospective payment system?

The outpatient prospective payment system will pay for:

- Some hospital outpatient (for example, stitches for a cut) and preventive services that you get in a hospital and are covered under Part B of the Original Medicare Plan.
- Some Part B services for inpatient hospital care (for example, diagnostic x-rays) given to Medicare patients who do not have **Medicare Part A** coverage or who have used up all of their Part A benefits.
- **Partial hospitalization** services for Medicare patients who go to a Community Mental Health Center.*
- Some preventive shots/vaccines (for example, a flu shot), antigens, casts, and splints you get from **Home Health Agencies**.
- Some preventive shots/vaccines (for example, a pneumonia shot) you get from **Comprehensive Outpatient Rehabilitation Facilities**.
- Splints, antigens, and casts (for example, a cast for a broken arm) given to **hospice** patients for the treatment of a non-terminal illness.
- Some outpatient services you get as a **Skilled Nursing Facility** patient.

Note: Before getting an outpatient service, you should check with your doctor or hospital to see if it will be paid for under the outpatient prospective payment system.

*For more information on partial hospitalization call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Medicare and Your Mental Health Benefits*.

Terms in **red** are defined in Section 5 on pages 23-25.

A Quick Look At The Outpatient Prospective Payment System (continued)

What services are not paid for under the outpatient prospective payment system?

These are some of the services that are **not** paid for under the outpatient prospective payment system. **However, Medicare pays for these services under other Medicare payment systems.**

- Clinical diagnostic laboratory services.
- Screening mammograms.
- Ambulance services.
- Physical therapy, occupational therapy, or speech-language therapy services.
- Orthotics, non-implantable prosthetics, or durable medical equipment.
- Dialysis for permanent kidney failure (**End-Stage Renal Disease**).
- Outpatient hospital services you get in **critical access hospitals** (small facilities that give limited outpatient and inpatient hospital services to people in rural areas).
- Outpatient services you get from an Indian Health Service hospital.
- Outpatient services you get in any hospital in the state of Maryland (Maryland hospitals are paid under Maryland's payment system).

For more detailed information on the outpatient prospective payment system, go to Section 2 on page 7.

Terms in **red** are defined in Section 5 on pages 23-25.

A Quick Look At Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older.
- Some people under age 65 with disabilities.
- People with **End-Stage Renal Disease** (permanent kidney failure requiring dialysis or a kidney transplant).

What is the Original Medicare Plan?

The Original Medicare Plan is a health plan that is available everywhere in the United States. It is the way most people get their **Medicare Part A** and Part B health care. You may go to any doctor, specialist, or hospital that accepts Medicare. You pay your share, and Medicare pays its share. Some things are not covered, like prescription drugs. For more information on the Original Medicare Plan, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to get a free copy of the publication *Medicare & You*, or look on the Internet at www.medicare.gov under Publications.

What is Medicare Part A?

Medicare Part A (Hospital Insurance)

Helps Pay For: Care in hospitals as an inpatient, critical access hospitals, skilled nursing facilities, hospice care, and some home health care.

Cost: Most people get Part A automatically when they turn age 65. They do not have to pay a monthly payment called a **premium** for Part A because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. You can call the Social Security Administration toll-free at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad

Terms in **red** are defined in Section 5 on pages 23-25.

A Quick Look At Medicare (continued)

Retirement Board, call your local RRB office or 1-800-808-0772.

What is Medicare Part B?

Medicare Part B (Medical Insurance)

Helps Pay For: Doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are **medically necessary**.

Cost: You pay the Medicare Part B **premium** of $45.50 per month. This is the 2000 amount and may change January 1, 2001. In some cases, this amount may be higher if you did not choose Part B when you first became eligible.

If you are not sure if you have Part A or Part B, look on your red, white, and blue Medicare card. It will show "Hospital Part A" and "Medical Part B" on the lower left corner of the card.

Terms in **red** are defined in Section 5 on pages 23-25.

Introduction To The Outpatient Prospective Payment System

The Balanced Budget Act of 1997 created a new way that Medicare will pay for most outpatient services covered by **Medicare Part B** in the Original Medicare Plan. This system is called the **outpatient prospective payment system** (PPS). This payment system only applies to **outpatient services** you get in a hospital or **community mental health center**. Most hospitals or community mental health centers will use this new system to figure out how much Medicare and you will pay for an outpatient service.

How are services paid under the outpatient prospective payment system?

Under this system, Medicare pays a set amount for some covered **outpatient services** you need to diagnose or treat an illness or injury. You must pay the yearly Medicare Part B **deductible** ($100 in 2000) and, depending on the service, a **coinsurance** or fixed **copayment** amount for each service.

What is an outpatient service?

An **outpatient service** is a service you get in one day (24 hours) at a hospital or community mental health center. This includes services like:

- Radiology (x-rays).
- Stitches for a cut.
- An emergency room visit.
- Getting a cast.

See page 3 for a more complete list of the services that are paid for under the outpatient prospective payment system.

What is the benefit of this new system?

Overall, it will lower the amount you must pay for your share (coinsurance or fixed copayment amount) of outpatient services. This will save you out-of-pocket costs over time.

Terms in **red** are defined in Section 5 on pages 23-25.

Introduction To The Outpatient Prospective Payment System (continued)

Does this new system change the way I get outpatient services?

No. You will get outpatient services the same way you always have. You can go to any hospital or **community mental health center** that participates in the Medicare program. **This system only changes the way that Medicare pays hospitals and community mental health centers for these services and how much you pay for outpatient services.** It does not affect how Medicare pays doctors' bills.

How It Works

How does the outpatient prospective payment system work?

Under the outpatient prospective payment system, hospitals and community mental health centers are paid a set amount of money (called the **payment rate**) to give some outpatient services to Medicare patients. The payment rate is the total payment that a hospital or community mental health center gets when they give outpatient services to Medicare patients. The payment rate includes: Medicare's payment amount for these services, your $100 yearly Medicare Part B deductible (if you have not already paid it for the year), and your coinsurance or fixed copayment amount (depending on the service).

Will all outpatient services I get be paid for under this new system?

No. Medicare does not pay for all outpatient department services under this new system (see page 4). In addition, Medicare will not pay for some surgical procedures if they are given on an outpatient basis (for example, fixing a fractured hip). Even though you could get these surgical procedures as an outpatient, Medicare considers them inpatient services. If you have one of these surgical procedures as an outpatient, you will have to pay the **full amount** the hospital charges for this service.

Terms in **red** are defined in Section 5 on pages 23-25.

How It Works (continued)

To avoid having to pay the full amount for the service, you should check with the hospital or your doctor to make sure that Medicare will pay for the surgical procedure you are getting as an outpatient. If Medicare does not pay for the surgical procedure because you are getting it as an outpatient, ask your doctor to put you in the hospital as an inpatient. Medicare will then pay for the procedure under Medicare Part A.

Will all hospitals and community mental health centers get the same payment rate?

No. The hospital or community mental health center will get a payment amount that reflects the wages in their area. Therefore, payment rates across the country will be different.

Will these payment rates change?

Yes. Medicare will update the payment rates on January 1 of each year to keep up with changes in the cost of providing services.

What You Pay

What will I have to pay under the outpatient prospective payment system?

You will have to pay:

- The **yearly** Medicare Part B **deductible** in the Original Medicare Plan ($100 in 2000).
- A **coinsurance** or fixed **copayment** amount for **each service** you get in an outpatient visit. For **each** outpatient service you get, this amount cannot be more than the **Medicare Part A** inpatient hospital deductible ($776 in 2000).
- All charges for items or services that Medicare does not cover.

Note: If you have a **Medigap** policy, other supplemental coverage, or employer or union coverage, it may pay for the Part B deductible and the coinsurance or fixed copayment amounts that the Original Medicare Plan does not cover. Therefore, if you didn't pay out-of-pocket for outpatient services in the past because you have other coverage, you won't have to pay out-of-pocket under the new system.

What is the difference between a coinsurance amount and a fixed copayment amount?

Depending on the service you get, you may have to pay a coinsurance amount or a fixed copayment amount. If the amount you must pay for the service is 20% of a hospital's charges or the Medicare payment rate, it is called coinsurance. If Medicare charges a fixed payment amount for the service you get, it is called a copayment.

How is my coinsurance or fixed copayment amount determined?

Under the outpatient prospective payment system, there are many factors that are used to figure out how much your coinsurance or fixed copayment amount will be for outpatient services. These factors include:

- The **national median charge** (exact middle amount) of the particular service.
- Hospital wages in the area where you get services.

Terms in **red** are defined in Section 5 on pages 23-25.

What You Pay (continued)

- Whether the hospital chooses to lower the fixed copayment amount for a particular service.
- Whether you have more than one surgical procedure at the same time. If you have more than one procedure at the same time, the payment rate may be lowered. This will make your coinsurance or fixed copayment amount lower.

Remember, the coinsurance or copayment amount you must pay for **each** service you get cannot be more than the Medicare Part A inpatient hospital deductible ($776 in 2000).

Note: If you have any questions about your bills, you should call your provider or the **Fiscal Intermediary** in your state (see pages 20-22).

Will the fixed copayment amount change each year?

The fixed **copayment** amount for each service you get will be the same each year until it equals 20% of the payment rate. Once this happens, the fixed copayment amount for any service may change each year. Then, it will no longer be called a fixed copayment amount, but rather will be called coinsurance.

Will my coinsurance amount change each year?

Your **coinsurance** amount for each service you get may change each year if the payment rate or hospital wages in your area change.

How are my costs different from what I paid for the same outpatient services before?

Old system: Before the outpatient prospective payment system, each hospital or **community mental health center** decided how much it was going to charge Medicare for each service you received. You then paid 20% of these charges. This 20% was your coinsurance amount.

Terms in **red** are defined in Section 5 on pages 23-25.

What You Pay (continued)

New system: Under the new **outpatient prospective payment system**, Medicare decides how much a hospital or community mental health center will get for each service you receive. Depending on the service, you then pay the coinsurance (20%) or fixed copayment amount (see Example 1).

Example 1 ▶

Mr. Davis went to the hospital outpatient department to have his cast removed. The hospital charges $100 for this procedure. However, the fixed copayment amount for this type of procedure, adjusted for wages in his area, is $16. Mr. Davis has already paid his yearly Medicare Part B deductible of $100. The chart below shows his costs under the old system versus the new outpatient prospective payment system.

	Old system	New outpatient prospective payment system
Costs	20% of the hospital's billed charges for removing the cast	A fixed copayment amount for this service
Mr. Davis must pay*	$20 (20% of $100)	$16

*If you have a **Medigap** policy, other supplemental coverage, or employer or union coverage with the Original Medicare Plan, it may pay your deductible and coinsurance or fixed copayment costs (see page 15).

Terms in **red** are defined in Section 5 on pages 23-25.

What You Pay (continued)

Will I be paying more or less for services under this new system?

After the **outpatient prospective payment system** is in place for a while (a few years), you will pay less for services than under the old system. In the meantime, what you pay will depend on which hospital or community mental health center you go to in your area and what they charged in the past for the service you need. This means that if you visit a hospital or community mental health center that had high charges for a particular service under the old system, your coinsurance or fixed copayment amount for that service will be lower than it was in the past. However, if you visit a hospital or community mental health center that had low charges for a particular service under the old system, your coinsurance or fixed copayment amount for that service may be higher than it was in the past for the first few years (see Example 2).

Example 2 ▶

Mr. Jacobs and Mrs. Smith both live in the same area. They are having the same outpatient procedure done, but at different hospitals. Mr. Jacobs' hospital charges $200 for this procedure while Mrs. Smith's hospital charges $150. However, the **national median charge** for this procedure is $175 (adjusted for wages in their area) with a fixed copayment amount of $37. They have both already paid their $100 yearly Medicare Part B deductible. The chart below shows the amounts they must pay under the old system and the new outpatient prospective payment system.

	Old system	New outpatient prospective payment system
Mr. Jacobs' payment share	$40 (20% of $200)	$37 (fixed copayment)
Mrs. Smith's payment share	$30 (20% of $150)	$37 (fixed copayment)

Terms in **red** are defined in Section 5 on pages 23-25.

What You Pay (continued)

Can hospitals lower the fixed copayment amount for services?

Hospitals may choose to lower the fixed **copayment** amount for certain services. However, they can lower this amount only for those services that are paid under the outpatient prospective payment system. The lower amount for any service cannot be below 20% of the payment rate.

If hospitals choose to lower the fixed copayment amount for certain services:

- They must keep this lower amount for one calendar year.
- They must bill all Medicare patients that get this service during that year the lower fixed copayment amount.
- They can advertise the lower amount.

Hospitals can decide each year if they will lower fixed copayment amounts for certain services. Only hospitals can decide whether to lower the fixed copayment amount (see Example 3). **Doctors and other providers are not allowed to lower the copayment amount.**

Example 3 ▶

Mr. Daniels goes to the hospital outpatient department because he needs stitches for a cut on his hand. He has already paid his $100 yearly Medicare Part B deductible. The fixed copayment amount for this service is $44. However, the hospital has chosen to accept $30 as the fixed copayment amount for this service. Because the hospital chose to lower the fixed copayment amount for this service, Mr. Daniels must pay $30 instead of $44.

Can I ask the hospital to lower the fixed copayment amount for an outpatient service I need?

No. Only hospitals can choose to lower the fixed copayment amount for certain services.

Terms in **red** are defined in Section 5 on pages 23-25.

What You Pay (continued)

Can hospitals lower the coinsurance amount for services?

No. The coinsurance amount cannot be lowered because coinsurance equals 20% of the **payment rate**.

About Your Bills

What happens after I get outpatient services?

After you get outpatient services that the Original Medicare Plan covers, your provider sends the bill to a private company (the **Fiscal Intermediary**) that handles outpatient bills for Medicare. After they process the bill, you will get a Medicare Summary Notice or an Explanation of Medicare Benefits. Please check the notice to be sure Medicare was not billed for services, medical supplies, or equipment that you did not get. If you have any questions about bills or services listed on the notice, call the health care provider or the Fiscal Intermediary in your state and ask about it. If you disagree with what is covered or paid, you have the right to file an appeal (see page 18).

How will I know what I will have to pay?

The Medicare Summary Notice and Explanation of Medicare Benefits will have a section showing the total deductible and coinsurance amount you are billed for the services you received. You need to look at this section because it lists the amount you have to pay for these services.

What if I have the Original Medicare Plan and other insurance?

If you have other supplemental insurance, such as a Medigap policy, it **may** pay for costs that the Original Medicare Plan does not cover. Your supplemental insurance may also pay for some services before the Original Medicare Plan will pay for the same service. If you have questions about who pays first, or how your other insurance pays for your outpatient services, call the benefits administrator for your plan. You can also call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-800-486-2048 for the hearing and speech impaired) and ask for a free copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First.*

Terms in **red** are defined in Section 5 on pages 23-25.

About Your Bills (continued)

Are there any changes to the Medicare Summary Notice or Explanation of Medicare Benefits because of the new outpatient prospective payment system?

Yes. There are some minor changes; however, **none of these will change how you get or pay for services**.

What if I paid more than the amount listed on the Medicare Summary Notice or Explanation of Medicare Benefits?

If the amount you paid the hospital or community mental health center at the time of service is more than what is listed on the Medicare Summary Notice or Explanation of Medicare Benefits, call the provider and ask for a refund. They must give you the difference between what you paid and the amount listed under the deductible and coinsurance section on the Medicare Summary Notice or Explanation of Medicare Benefits.

What if I paid less than the amount listed on the Medicare Summary Notice or Explanation of Medicare Benefits?

If you paid less than the amount listed under the deductible and coinsurance section on the Medicare Summary Notice or Explanation of Medicare Benefits, the hospital or community mental health center may bill you for the difference.

If you have a Medigap policy or other supplemental insurance, it may pay some of these costs. Check with your insurance company or benefits administrator to see how your coverage works with the Original Medicare Plan.

Who should I call if I think these charges are wrong?

If you see a charge on the Medicare Summary Notice or Explanation of Medicare Benefits that may be wrong, call the health care provider and ask about it. If you think that a provider may be cheating or abusing Medicare, call the **Fiscal Intermediary** that sent you the notice. Their phone number is printed on the front of the notice.

Your Medicare Patient Rights

If you have Medicare, you have certain guaranteed rights.

Information:

You have the right to receive easy-to-understand information about Medicare, what costs it pays, and how much you have to pay. And you have a right to know what to do if you have to file a complaint.

Emergency Care:

You have the right to get emergency care when and where you need it. You don't need an OK from your health plan. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.

Appeals:

You have the right to file an appeal if Medicare does not pay for a covered service you have been given, or if your health plan does not give you a service that you believe should be provided.

Treatment Choices:

You have the right to know all your treatment options from your health care provider in language that is clear to you, and in a language that you understand.

Privacy:

You have the right to have any personal information that Medicare collects kept private. Medicare may collect information about you as part of its regular business, such as paying your bills. When Medicare asks for this kind of information, we must tell you that the law lets us collect it, why it is being collected, whether it is required or optional, what happens if you don't give the information, and how it will be used. If you want this information, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for more information about how Medicare uses personal information.

Your Medicare Appeal Rights

You have the right to appeal any decision about your Medicare services. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal. If you need help filing an appeal, call the **State Health Insurance Assistance Program** in your state (see pages 20-22). For more information abour your appeal rights, call 1-800-MEDICARE and ask for a free copy of *Medicare Appeals and Grievances (Complaints)*.

Your Medicare Protections

You are protected from discrimination.

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, or sex under certain conditions. If you think that you have not been treated fairly for any of these reasons, call the Office for Civil Rights at 1-800-368-1019.

What can I do if I am concerned about the quality of my care?

If you believe that the hospital or community mental health center is not giving you good quality care, call the **Peer Review Organization** in your state (see pages 20-22).

Terms in **red** are defined in Section 5 on pages 23-25.

SECTION 4 - FOR MORE INFORMATION

For more information about Medicare-related topics:

Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of:

- ***Medicare & You*** - This handbook gives basic information about Medicare coverage and benefits, health plan choices, and protections and rights.
- ***Guide to Health Insurance for People with Medicare*** - This booklet gives information on buying and using a Medigap policy and other types of insurance.
- ***Medicare and Other Health Benefits: Your Guide to Who Pays First*** - This booklet gives information about how Medicare works with other types of insurance.
- ***Medicare and Your Mental Health Benefits*** - This booklet explains your mental health benefits under the Original Medicare Plan.
- ***Medicare Appeals and Grievances (Complaints)*** - This booklet explains your Medicare appeal rights.
- ***Medicare Patient Rights*** - This booklet provides a brief description of your rights as a Medicare beneficiary.
- ***Do You Need Help to Pay Health Care Costs?*** - This flyer explains where you can get help to pay for health care costs.

You can also look on the Internet at www.medicare.gov for information about Medicare-related topics, and to read and print Medicare booklets like those listed above.

Fiscal Intermediary: Call about outpatient bills and services, and fraud and abuse.

Peer Review Organization: Call about quality of care concerns, filing an appeal or complaint, and questions about your rights as a hospital patient.

State Health Insurance Assistance Program: Call about help with filing an appeal and other general insurance questions.

State	Fiscal Intermediary	Peer Review Organization	State Health Insurance Assistance Program
Alabama	(402) 351-2860	(800) 760-4550	(334) 242-5743
Alaska	(425) 670-1010	(800) 878-7170	(907) 269-3680
American Samoa	(808) 942-2400	(800) 524-6550	(808) 586-7299
Arizona	(800) 232-2345 x4298	(800) 359-9909	(800) 432-4040
Arkansas	(877) 356-2368	(800) 272-5528	(800) 224-6330
California	(805) 383-2038	(800) 841-1602	(800) 434-0222
Colorado	(800) 442-2620	(800) 727-7086	(303) 894-7499 x356
Connecticut	(203) 639-3222	(800) 553-7590	(860) 424-5245
Delaware	(800) 442-8430	(302) 475-8100	(302) 739-6266
Florida	(904) 355-8899	(800) 844-0795	(850) 414-2060
Georgia	(706) 322-4082	(800) 979-7217	(404) 657-5334
Guam	(808) 942-2400	(800) 524-6550	(808) 586-7299
Hawaii	(808) 942-2400	(800) 524-6550	(808) 586-7299
Idaho	(503) 721-7000	(800) 445-6941	(208) 334-4350
Illinois	(312) 938-6266	(800) 647-8089	(217) 785-9021
Indiana	(800) 622-4792	(800) 288-1499	(800) 452-4800
Iowa	(712) 279-8650	(800) 752-7014	(800) 351-4664
Kansas	(800) 445-7170	(800) 432-0407	(316) 337-7386
Kentucky	(800) 999-7608	(800) 288-1499	(502) 564-7372
Louisiana	(800) 932-7644	(225) 926-6353	(225) 342-0825

State	Fiscal Intermediary	Peer Review Organization	State Health Insurance Assistance Program
Maine	(888) 896-4997	(603) 749-1641	(800) 750-5353
Maryland	(800) 655-1636	(800) 492-5811	(410) 767-1100
Massachusetts	(888) 896-4997	(781) 890-0011	(617) 727-7750
Michigan	(313) 225-8317	(800) 365-5899	(800) 803-7174
Minnesota	(800) 330-5935	(800) 444-3423	(800) 333-2433
Mississippi	(800) 932-7644	(800) 844-0600	(800) 948-3090
Missouri	(800) 932-7644	(800) 347-1016	(800) 390-3330
Montana	(800) 447-7828 x4086	(800) 497-8232	(406) 444-7781
Nebraska	(402) 390-1850	(800) 247-3004	(800) 234-7119
Nevada	(805) 383-2038	(800) 748-6773	(800) 307-4444
New Hampshire	(800) 522-8323	(603) 749-1641	(603) 225-9000
New Jersey	(973) 456-2112	(732) 238-5570	(609) 588-3139
New Mexico	(800) 442-2620	(800) 279-6824	(505) 827-7640
New York	(800) 442-8430	(800) 331-7767	(800) 333-4114
North Carolina	(919) 688-5528	(800) 722-0468	(919) 733-0111
North Dakota	(800) 247-2267	(701) 852-4231	(701) 328-2440
Ohio	(513) 852-4314	(800) 589-7337	(614) 644-3458
Oklahoma	(918) 560-3367	(405) 840-2891	(405) 521-6628
Oregon	(503) 721-7000	(800) 344-4354	(503) 947-7984
Pennsylvania	(800) 853-1419	(800) 322-1914	(800) 783-7067

State	Fiscal Intermediary	Peer Review Organization	State Health Insurance Assistance Program
Puerto Rico	(787) 758-9720	(787) 641-1240	(787) 721-8590
Rhode Island	(800) 662-5170	(800) 662-5028	(401) 222-2880
South Carolina	(803) 788-4660	(803) 731-8225	(803) 898-2850
South Dakota	(712) 279-8650	(800) 658-2285	(605) 773-3656
Tennessee	(423) 755-5955	(800) 489-4633	(800) 525-2816
Texas	(800) 442-2620	(800) 725-8315	(800) 252-9240
Utah	(801) 333-2410	(800) 274-2290	(801) 538-3910
Vermont	(800) 522-8323	(603) 749-1641	(800) 642-5119
Virgin Islands	(787) 758-9720	(340) 712-2400	(340) 778-6311 x2338
Virginia	(540) 985-3931	(804) 289-5304	(800) 552-3402
Washington	(425) 670-1010	(800) 445-6941	(800) 397-4422
Washington D.C.	(402) 351-2860	(800) 645-0011	(202) 676-3900
West Virginia	(540) 985-3931	(800) 642-8686 x2266	(877) 987-4463
Wisconsin	(414) 224-4954	(800) 362-2320	(877) 333-0202
Wyoming	(888) 557-2301	(800) 497-8232	(800) 856-4398

At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or go to the Internet at www.medicare.gov and pick Helpful Contacts.

Coinsurance - The percent of the Medicare payment rate or a hospital's billed charges that you have to pay after you pay the deductible for Part B services.

Community Mental Health Center - A place where Medicare patients can go to receive partial hospitalization services (see Partial Hospitalization).

Comprehensive Outpatient Rehabilitation Facility (CORF) - A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

Copayment - Under the outpatient prospective payment system, the fixed amount you pay for each outpatient service you get.

Critical Access Hospital - A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Deductible - The amount you must pay for health care each calendar year before Medicare begins to pay. This amount can change every year.

***End-Stage Renal Disease (ESRD)** - Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant. ESRD patients are eligible for Social Security payments if found to be disabled.

Fiscal Intermediary - A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

Home Health Agency - An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Hospice - Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (hospital insurance).

Medically Necessary - Service or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

* This definition, whole or in part, was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology, 2000.

Medicare Managed Care Plan - Health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Part A (Hospital Insurance) - Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

Medicare Part B (Medical Insurance) - Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.

Medigap - A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized policies, labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

National Median Charge - The national median charge is the exact middle amount of the amounts charged for the same service. This means that half of the hospitals and community mental health centers charged more than this amount and the other half charged less than this amount for the same service.

Original Medicare Plan - A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Outpatient Prospective Payment System - The new way that Medicare will pay for most outpatient services at hospitals or community mental health centers under Medicare Part B.

Outpatient Services - A service you get in one day (24 hours) at a hospital outpatient department or community mental health center.

Partial Hospitalization - A structured program of active treatment for psychiatric care that is more intense than the care received in your doctor's or therapist's office.

Payment Rate - The total payment that a hospital or community mental health center gets when they give outpatient services to Medicare patients.

Peer Review Organization (PRO) - Groups of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service plans, and ambulatory surgical centers.

Premium - The amount you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Private Fee-for-Service Plan - A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Skilled Nursing Facility - A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.

State Health Insurance Assistance Program (SHIP) - A state program that gets money from the federal government to give free health insurance counseling and assistance to people with Medicare.

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NOTES

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Health Care Financing Administration
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Baltimore, MD 21244

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